

APPENDIX 1b
AMBULANCE - EMERGENCY TRIP

HEALTH INSURANCE CLAIM FORM

1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> (Medicare #) (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID)		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 1234567890	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Recipient, Ima A.		3. PATIENT'S BIRTH DATE MM DD YY M 1 X F	
5. PATIENT'S ADDRESS (No., Street) 609 Willow St.		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
7. INSURED'S ADDRESS (No., Street)		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>	
CITY Anytown		CITY	
STATE WI		STATE	
ZIP CODE 55555		ZIP CODE	
TELEPHONE (Include Area Code) (XXX) XXX - XXXX		TELEPHONE (INCLUDE AREA CODE) ()	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) OI-D		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. INSURED'S DATE OF BIRTH MM DD YY M 1 X F	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M 1 X F		b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____	
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. V919 2. _____ 3. _____ 4. _____		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. Place of Service C. Type of Service D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS CODE F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. EMG J. COB K. RESERVED FOR LOCAL USE			
1. MM DD YY 1 9 A0010 1 XX XX 1 E			
2. MM DD YY 1 9 A0020 1 XX XX 15 E			
3.			
4.			
5.			
6.			
25. FEDERAL TAX I.D. NUMBER SSN EIN		26. PATIENT'S ACCOUNT NO 1234JED	
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ XXX XX	
29. AMOUNT PAID \$ 0 00		30. BALANCE DUE \$ XXX XX	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) I.M. Authorized SIGNED _____ DATE MM/DD/YY		32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) 11223344	
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # I.M. Billing 1 W. Williams Anytown, WI 55555 76543218		PIN# _____ GRP# _____	